VERIFICATION OF EXPECTED ADULT DEATH TRAINING

For Qualified Nurses working in the Community and in Care Homes

Verification of expected death in the community needs to take place in a timely way.

Due to pressures on GP services, both in and out of hours, and the obvious need to prioritize care to those in most urgent need there can be considerable delay between time of death and the time the patient is seen by a doctor and death formally verified. This delay could cause potential stress to relatives and carers. As there is no legal obligation for a Dr to verify death this provides an opportunity for nurses to increase their knowledge, expertise and autonomous practice.

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Learning Strategy

Qualified Nurses are invited to attend a 2 hour study session on the verification of expected adult death.

Following the study session you will be required to undertake one observed practice of verification of death. However if you feel that you need more observed practice then you can negotiate this with your Assessor.

It is important to remember that once any skill or area of knowledge had been learnt, it is the responsibility of the individual to maintain and improve knowledge and competence (NMC 2004 Code of Conduct).

ASSESSMENT STRATEGY

Following the training session the Nurse will return to the clinical area and fulfil the following procedure chronologically.

1 Observation. The Nurse will observe the verification of death by a competent trained practitioner in his/her own clinical area.

2 Supervised Practice. A period of supervised practice will be undertaken and the Nurse will be supervised in the procedure for the verification of death.

3 Assessment Will be conducted by a Trained Nurse/Medical practitioner who is competent in the verification of death.

4 A Competency based assessment will be completed and reviewed annually
FLOW CHART FOR VERIFICATION OF EXPECTED DEATH OF AN ADULT
BY
REGISTERED NURSES WORKING IN THE COMMUNITY

Death expected
Palliative care being provided by medical and nursing staff
MDT decision made for no active medical intervention

↓
GP communicates with nursing staff regarding those patients identified as an expected death and confirms whether nursing staff can make the verification Decision documented in district nursing records (LCP)

↓
Patient dies at home
Relatives contact D/N or other nursing team¹

↓
Nurse who has been deemed competent to verify expected adult death checks physiological signs to ascertain that death has occurred

↓
Nurse completes proforma x2 for verification of expected adult death (appendix 2) and files in district nursing record

↓
Last offices performed and referral made to family’s choice of funeral director
Information (Help for Bereaved Booklet) provided

↓
Death notified to patient’s GP as soon as possible within the next working day via telephone in hours and proforma for verification of expected adult death sent

↓
GP issues death certificate within 24 hours or next working day

¹ This may not apply in a Care Home setting

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